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ABSTRACT

This paper reviews the research literature from 1978 to 1991 that addresses long-term effects of childhood sexual abuse on adult women's sexual functioning. Frequently reported long-term effects of childhood sexual abuse are noted, including both sexual dissatisfaction and sexual dysfunction. In terms of sexual dysfunction, it is noted that adult women molested as children may experience response inhibiting problems including fear of sex, desire dysfunction, and arousal dysfunction; orgasmic problems; and intromission problems. Incidents of flashbacks during sexual activities and increased rates of subsequent sexual assault as reported by women who were sexually abused as children are discussed. Various methodological problems of the existing research are addressed, including differences in definitions of sexual abuse, descriptions of victims and perpetrators, the nature of the sample used (sample size, clinical versus nonclinical samples, lack of appropriate control of comparison groups), and data collection and measurement issues. The review concludes that there is a need for: (1) more empirical research which utilizes large nonclinical or combined samples, control or comparison groups, standardized measures, and statistical analysis of the data; (2) operationalized definitions of sexual abuse to ease comparisons across studies; and (3) the development and utilization of special outcome measures of child sexual abuse. (Contains 35 resources.) (NB)

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THE SEXUAL FUNCTIONING OF ADULT WOMEN MOLESTED AS CHILDREN: A REVIEW OF EMPIRICAL STUDIES

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THE SEXUAL FUNCTIONING OF ADULT WOMEN MOLESTED AS CHILDREN: A REVIEW OF EMPIRICAL STUDIES

A Doctoral Research Paper

Presented to

the Faculty of Rosemead School of Psychology

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Doctor of Psychology

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by

Julie Lynn Clarke

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ABSTRACT

THE SEXUAL FUNCTIONING OF ADULT WOMEN MOLESTED AS CHILDREN: A REVIEW OF EMPIRICAL STUDIES

by

Julie Lynn Clarke

This paper reviews the literature addressing long-term effects of childhood sexual abuse on adult women's sexual functioning. Frequently reported long-term effects include both sexual dissatisfaction and sexual dysfunction. In terms of sexual dysfunction, adult women molested as children may experience response inhibiting problems including fear of sex, desire dysfunction, and arousal dysfunction; orgasmic problems; and intromission problems including dyspareunia and vaginismus. Also, flashbacks during sexual activities and increased rates of subsequent sexual assault are reported by women who were sexually abused as children. Research from 1978 to 1991 is reviewed and various methodological problems of the existing research are addressed, along with suggestions for future research.

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THE SEXUAL FUNCTIONING OF ADULT WOMEN MOLESTED AS CHILDREN: A REVIEW OF EMPIRICAL STUDIES

Introduction

While the sexual abuse of female children in United States society has increasingly become recognized and acknowledged, psychological research and documentation are still in the beginning stages. There have been many studies of the incidence and prevalence of women molested as children, but the true extent of childhood sexual abuse remains essentially unknown. This is due to many factors, including non-standard definitions of childhood sexual abuse and designations of ages of victims and perpetrators. In addition, estimates are often based on non-representative subject samples. Bachmann, Moeller, and Bennett (1988) reviewed the literature on childhood sexual abuse and found that estimates of the incidence of sexual abuse varied from 15% to 38%.

Russell (1983) included a random sample of 930 adult women in her study of sexual abuse among female children. She created a standardized interview and carefully selected and trained female interviewers. At least one experience of sexual abuse before the age of 14 years was reported by 28% of women, while 38% reported at least one experience before the age of 18. Before the age of 18 years, 16% of women reported at least one experience of intrafamilial sexual

abuse, while 31% reported at least one experience of extrafamilial sexual abuse.

Findings similar to Russell's (1983) have been reported in studies with female undergraduates. Fromuth (1986) found that 22% related histories of sexual abuse before the age of 17, and Briere and Runtz (1990) discovered that 14.7% had been sexually abused before the age of 15. Alexander and Lupfer (1987) found that 25% reported at least one experience of childhood sexual abuse, but these researchers did not provide their delineation of the age-range of childhood.

Long-term effects of childhood sexual abuse have been identified through research. These include emotional effects such as anxiety, depression, fearfulness, feelings of guilt, and low self-esteem (Bachmann et al., 1988; Browne & Finkelhor, 1986; Cahill, Llewelyn, & Pearson, 1991; Herman, Russell, & Trocki, 1986). Various behavioral effects of childhood sexual abuse have also been found, including alcohol or substance abuse, eating disorders, self-destructiveness, suicide attempts, and prostitution (Bachmann et al., 1988; Briere & Runtz, 1988; Browne & Finkelhor, 1986; Cahill et al.,1991). Relationship effects, including interpersonal difficulties, inadequate social skills, feelings of isolation, mistrust of others, fear of intimate relationships with men, and sexual problems have also been identified (Browne & Finkelhor, 1986; Cahill et al., 1991; Herman et al., 1986; McCabe, 1989).

Medical and physical problems such as asthma, heart palpitations, spastic colon, stomach pain, ulcer, headaches, chronic

pelvic pain, fainting and dizziness have also been found among women sexually abused as children (Bachmann et al., 1988; Cunningham, Pearce, & Pearce, 1988; Maltz, 1990). In addition, research in the last 9 years has revealed that women who were molested as children are more likely to be revictimized as adults than women who were not molested (Alexander & Lupfer, 1987; Becker, Sinner, Abel, Axelrod, & Cichon, 1984; Briere & Runtz, 1987; Fromuth, 1986; Gorcey, Santiago, & McCall-Perez, 1986; McCord, 1985).

Throughout the last 15 years, there has been increasing attention focused on the effects of childhood sexual abuse and incest on developing sexuality and adult psychological and sexual functioning. Studies of these effects have identified sexual dissatisfaction and various types of sexual dysfunction. The purpose of this paper is to review the existing literature on the long-term effects of childhood sexual abuse on adult women's sexual satisfaction and functioning. Sexual satisfaction and functioning, as well as specific sexual dysfunctions of adult women molested as children, will be considered. Also included in this paper are a review of methodological problems of the existing research and recommendations for future research. The discussion begins with methodological considerations and an overview of the literature.

Methodological Considerations

The majority of studies examining the impact of child sexual abuse on adult women's sexual satisfaction and functioning suggest that such abuse is associated with varying levels of dysfunction.

Despite consistent findings in the literature, however, there are methodological problems to consider in the existing research. These include differences in definitions of sexual abuse, descriptions of victims and perpetrators, the nature of the sample utilized (e.g., sample size, clinical versus nonclinical, lack of appropriate control or comparison group), and data collection and measurements (e.g., standardized versus non-standardized tests; lack of specific sexual abuse instruments). Methodological differences such as these throughout the research made it difficult to compare studies, statistics, and results.

Definitions

There is no standard definition of childhood sexual abuse in the United States. Each state has its own laws which define child abuse and, more specifically, sexual abuse. Sexual abuse, as defined in the literature, may include only sexual contact such as fondling to intercourse (Briere & Runtz, 1987), or may include non-coital and non-contact experiences such as being forced to watch sexual acts or participate in child pornography (Maltz, 1990). In addition, there is no consensus in the literature regarding the age-range of childhood.

It is difficult to compare studies of childhood sexual abuse and their findings when differential definitions are utilized. In some studies a child is designated as being under 18 years of age; in others, under 15 years of age; and in still others, under 14 years. In addition, definitions of sexual abuse typically include an age differential between perpetrator and victim which varies in the literature. Age differentials of five or more years are most common, with some variations based on

the age of the child. For example, Briere and Runtz (1987) operationally defined sexual abuse as sexual contact (e.g., fondling to intercourse) before the age of 15 by someone five or more years older. Fromuth (1986) also specified that sexual abuse be initiated by someone five years the victim's senior and at least 16 years old if she was 12 years old or younger, but 10 years her senior if she was 13-16 years of age. Such differences in definitions of sexual abuse and age designations introduce sources of variance that make comparisons across studies difficult to interpret.

Samples

The nature of samples utilized in research on adult women molested as children and sexual satisfaction and functioning vary. Among the empirical studies reviewed here, the number of subjects ranged from 8 to 586. While a sample of 8 is rather small, the vast majority of the studies reviewed employed adequate and large sample sizes. Most of the subjects in the studies reviewed were volunteers, either women responding to public advertisement or women seeking or involved in treatment. It has been argued that women who volunteer to participate in research may not provide a representative sample (Gorcey et al., 1986). Women who volunteer could be more likely to suffer from severe problems and thus be more motivated to participate, or could be less sensitive to sexual issues and thus more motivated to participate (Fromuth, 1986). It has been suggested by Courtois (1979) that the benefits of differential sampling, including the utilization of volunteers, outweigh the liabilities. She purports that the use of volunteers allows researchers to study populations that are

more heterogeneous in nature than, for example, strictly clinical populations.

Research in this area has been criticized for its over-reliance on clinical subjects (Becker, Skinner, Abel, & Cichon, 1986; Maltz & Holman, 1987; Tsai & Wagner, 1978). Clinical subjects have been considered to exhibit more frequent or severe problems than non-clinical subjects (Becker, Sinner, Abel, & Treacy, 1982; Gorcey et al., 1986; Greenwald, Leitenberg, Cado, & Tarran, 1990) and thus may bias findings in the direction of women who are functioning more poorly than, say, a community or non-clinical sample. The 26 empirical studies described herein considered both clinical and non-clinical subjects. Among these studies, 12 were composed of clinical subjects, 10 were non-clinical, and 4 utilized both clinical and non-clinical subjects.

Within the categories of clinical and non-clinical subjects, great variety was represented among studies. Clinical subjects included sexual abuse, incest, rape, and sexual assault survivors in treatment. Non-clinical subjects included women who were sexually abused, victims of incest or rape in childhood and/or adolescence, college students, and employed nurses. While clinical subjects may bias findings in the direction of lower functioning, non-clinical samples may bias findings in the direction of higher functioning. For example, it has been suggested that college students may be too young a population to yield long-term effects of childhood sexual abuse, therefore, a valid assessment may not be possible (Greenwald et al., 1990). This seems a particularly significant perspective considering

that DSM-III-R (American Psychiatric Association [APA], 1987) has noted the most common onset of sexual dysfunction as early adulthood, "late 20s and early 30s, a few years after establishment of sustained sexual relationship" (p. 292), which is older than the typical college student in his/her early 20s. Among the five studies that failed to show results indicative of childhood sexual abuse affecting adult women's sexual satisfaction and functioning, four focused on female undergraduates.

Research in this area has also been criticized for its lack of appropriate control or comparison groups. Among the 26 empirical studies reviewed here, 12 utilized a control or comparison group while 14 did not. Control groups are important within a study in order to provide a comparison group to other subjects who are different in some way (e.g., sexually abused women not in treatment, women who were not sexually abused). Alter-Reid, Gibbs, Lachenmeyer, Sigal, and Massoth (1986), in their review of empirical findings, also suggested that "lack of inclusion of control or comparison groups does not permit the reader to compare symptomatology with other clinical populations and the general population" (p. 259).

Because of the nature of investigation (sexual abuse), it was not possible for researchers to randomly assign subjects to various conditions. In addition, the vast majority of studies reviewed did not employ random sampling, which is largely unfeasible in this population. Due to both the lack of random assignment and random sampling, generalizability of results is limited and cannot be applied to

the general population. However, generalization to the clinical population may be very useful at this time.

Measurement

The collection of data has also been a source of concern throughout the research. The research reviewed employed the interview method, retrospective reporting, and a wide variety of other measures. It has been suggested by some researchers that the utilization of self-report and retrospective material may open up the possibility of differential recall, conscious distortion, and/or memory deficits regarding molestation experiences (Becker et al., 1986; Gorcey et al., 1986; Jackson, Calhoun, Amick, Maddever, & Habif, 1990; Tsai, Feldman-Summers, & Edgar, 1979). Others, like Courtois (1979), consider retrospective reporting to yield first-hand information and thus be superior to second-hand records or impressions.

Various measures were utilized by researchers in studies on sexual satisfaction and functioning of sexual abuse survivors. These included structured interviews, standardized instruments, researcher-created measures, DSM-III (American Psychiatric Association [APA], 1980) and DSM-III-R (APA, 1987) categories of female sexual dysfunction, and examination of patient charts. Some researchers used only a structured interview to obtain data, but the majority employed additional measures (e.g., standardized or researcher-created instruments). Standardized instruments included the Derogatis Sexual Functioning Inventory, the Sexual Arousability

Inventory, the Beck Depression Inventory, the Spielberger State-Trait Anxiety Inventory, and the Fear Survey Interview.

Some researchers created their own measures including the Sexual Satisfaction Questionnaire (Langmade, 1983), Sexual Experiences Questionnaire (Tsai et al., 1979), Impact Interview (Gorcey et al., 1986), and scales of sexuality, current sexual adjustment, satisfaction and functioning (Alexander & Lupfer, 1987; Briere & Runtz, 1990; Fromuth, 1986; Greenwald et al., 1990; Maltz & Holman, 1987). Others categorized subjects into specific sexual dysfunctions (Becker et al., 1982; Becker et al., 1984; Becker et al., 1986; Jehu, 1989; Jehu, Gazan, & Klassen, 1985) and one examined emergency room patient charts (Briere & Zaidi, 1989). Some investigators, however, failed to adequately describe measurement instruments they utilized and referred to them simply as standardized measures or paper and pencil tests (Becker et al., 1982; Becker et al, 1984; Becker et al., 1986).

There are several problems with the utilization of such diverse measures and the lack of specific sexual abuse instruments. To begin with, the utilization of such diverse measures, including research-created measures, makes it difficult to compare findings across studies. In addition, some researcher-created measures may not be sensitive enough to clarify findings or detect differences between groups (Alexander & Lupfer, 1987). Browne and Finkelhor (1986) noted that many of the studies utilize subjective rather than objective measures. They suggested that "to test for the specific and diverse sequelae that have been associated with child sexual abuse, it would

appear that special sexual abuse outcome instruments now need to be developed" (p. 76).

Other Factors

There may be other factors not controlled for by the research designs which account for sexual dissatisfaction and dysfunction of adult women molested as children. Pre-morbid factors such as neglect, family conflict, paternal dominance, or parental alcoholism could contribute to long-term effects on sexuality or at the least could have made children vulnerable to sexual abuse (Browne & Finkelhor, 1986). For example, Jackson et al. (1990) found significant differences between groups of subjects on variables of family environments and noted that "these differences suggest that family characteristics associated with sexual abuse may be important contributors to the later observed adjustment problems" (p. 218). Briere and Runtz (1990) designed their study to examine the relationship between three forms of child abuse (psychological, physical, and sexual) and three forms of psychological symptomatology (self-esteem, anger/aggression, and dysfunctional sexual behavior). Their results indicated that "the various types of child abuse have both specific and overlapping effects on later psychosocial functioning" (p. 361).

There are numerous methodological problems to consider as one evaluates the literature addressing long-term effects of childhood sexual abuse on adult women's sexual functioning. These include the utilization among studies of differential definitions of sexual abuse and

descriptions of victims and perpetrators, in addition to sampling, measurement, and uncontrolled discrepancies.

Overview of Empirical Research

Sexual problems have been found through research to be associated with childhood sexual abuse among adult women. In general, long-term effects of female sexual abuse appear to include sexual dissatisfaction and sexual dysfunction. The research pertaining to sexual dissatisfaction and dysfunction among women who were sexually abused during childhood is reviewed below. In addition, the DSM-III-R (APA, 1987) definition of sexual dysfunction is presented, along with the specific female sexual dysfunctions they identify.

Sexual Satisfaction

The majority of research on the sexual satisfaction of adult women who were molested as children has shown that sexual dissatisfaction is correlated with the occurrence of childhood sexual abuse. Two of the studies reviewed, however, reported nonsignificant findings. Alexander and Lupfer (1987) found that the sexual satisfaction of female undergraduates who were sexually abused as children was not significantly affected by either the occurrence of abuse or the type of abuse. Greenwald et al. (1990) found no significant differences between women nurses sexually abused as children and a control group in terms of sexual dissatisfaction. Women in this study were sexually abused at age 15 or younger and their perpetrators were at least five years their senior and a minimum of 16 years old.

The findings of the majority of studies reviewed suggest that sexual satisfaction of adult women molested as children is decreased by the occurrence of such abuse. Significant differences between groups of subjects were reported by several researchers. Langmade (1983) considered 68 subjects who comprised a clinical group of incest survivors in treatment and a control group. His findings revealed that the incest group experienced significantly greater dissatisfaction with sexual relationships than the control group ($p < .01$). Similarly, Jackson et al. (1990) studied 22 female incest survivors (designated as occurring before the age of 18 with the perpetrator at least five years her senior) and a matched comparison group of 18 women with no reported childhood sexual abuse. They found that women with sexual abuse histories reported significantly less sexual satisfaction than women who were not abused ($p < .01$).

Other studies have also shown that women who were sexually abused in childhood experience sexual dissatisfaction. In their study of eight women who had experienced childhood and/or adolescent incest, Van Buskirk and Cole (1983) found that the majority reported poor sexual and emotional satisfaction with males. Jehu et al. (1985) found that 50% of adult women molested as children seeking treatment experienced sexual dissatisfaction. Similarly, Jehu (1989) found that 58.8% of adult survivors entering treatment reported sexual dissatisfaction.

The majority of research reviewed shows that women who were molested as children often experience sexual dissatisfaction. Two studies, however, failed to report significant findings; both of these

studies (Alexander & Lupfer, 1987: Greenwald et al., 1990) considered non-clinical populations and appear biased toward higher functioning samples of sexually abused subjects (e.g., female college students and employed women nurses). The studies that reported significant findings and sexual dissatisfaction among adult survivors considered both clinical and non-clinical populations. These included incest survivors in the community (not in treatment), seeking treatment, and in treatment, and sexually abused women seeking and entering treatment.

Sexual Functioning

The majority of research on the sexual functioning of adult women who were molested as children suggests that sexual dysfunction is correlated with the occurrence of sexual abuse. Three of the studies reviewed, however, reported no significant findings. In their studies of female college students, neither Fromuth (1986) nor Alexander and Lupfer (1987) found significant differences between women who were sexually abused as children and non-abused women in terms of sexual functioning. Similarly, Greenwald et al. (1990), in their study of sexual dysfunction (N = 108 nurses), found no significant differences between subjects who were sexually abused as children and a control group.

The vast majority of studies reviewed reported findings that suggest adult women's sexual functioning is affected by the occurrence of childhood sexual abuse. Significant findings were reported by many researchers. Tsai et al. (1979) considered three groups of 30 women in their study: (a) a group of women with histories of childhood sexual

abuse who were seeking treatment, (b) a group of women with histories of sexual abuse who had never sought treatment, and (c) a matched control group of women who had no history of childhood sexual abuse and had never sought treatment. On measures of psychosexual functioning and the MMPI, women in the clinical group were found to be significantly less well-adjusted than the non-clinical and control group. In another study (Meiselman, 1980), the MMPI records of 16 female psychotherapy clients with no histories of incest were compared with 16 matched clients with no history of incest. Although the mean MMPI profiles of the incest and control groups were very similar, she found that women in the incest group answered significantly more of the critical items on the MMPI in the direction of sexual disturbance ($p < .05$).

In 1983, Langmade found that adult women with histories of incest reported experiencing significantly more sexual anxiety and sexual guilt than the control group ($p < .01$). Survivors of sexual assault (defined as child molestation, incest, rape, and attempted rape) reported significantly more sexual problems than the comparison group in Becker et al.'s (1986) study. Similarly, in Briere and Runtz's (1987) study of women presenting for treatment at a crisis counseling department of a community health center, subjects with sexual abuse histories were significantly more likely to report sexual difficulties than non-abused subjects ($p < .0001$).

Briere and Zaidi (1989) examined 50 randomly selected charts of women evaluated in a psychiatric emergency room. They also examined 50 women's charts completed after asking the intake

clinicians to routinely inquire about childhood sexual abuse (designated as before age 17, with the perpetrator five or more years her senior). The incidence of childhood sexual abuse significantly increased from the randomly selected files (6%) to those examined after making requests that the intake clinicians query on abuse history (70%) ($p < .0001$). A significantly higher incidence of sexual problems was also found among women with histories of childhood sexual abuse compared to those with no history of abuse ($p < .01$).

In their study of the differential symptomology associated with various types of child abuse, Briere and Runtz (1990) considered 277 female undergraduates. Sexual abuse histories (victim designated as 14 years or younger and the perpetrator at least five years her senior) were reported by 14.7% of their subjects. A statistically significant relationship was found between childhood sexual abuse and dysfunctional adult sexual behavior. The findings of this study seem particularly noteworthy due to Briere and Runtz's (1990) research design. They controlled for other types of childhood abuse (i.e., physical, psychological) in order to determine what forms of abuse are associated with specific later difficulties.

Other studies have also found that women who were sexually abused in childhood experience dysfunction. Gorcey et al. (1986) and Jehu (1989), in their studies of women with histories of childhood sexual abuse, found that 85% and 78%, respectively, reported experiencing at least one sexual dysfunction. Additionally, Jackson et al. (1990) found that 65% of the incest victims in their study met criteria for one or more DSM-III (APA, 1980) sexual dysfunctions. It is

interesting to note that although the Jackson et al.'s article was published in 1990, these investigators utilized the DSM-III (APA, 1980) rather than the DSM-III-R (APA, 1987) criteria for sexual dysfunction.

In studies of sexual assault (Becker et al., 1982; Becker et al., 1984; Becker et al, 1986), women survivors were also found to experience sexual dysfunction. Sexual problems were reported by 59% of sexual assault survivors (including incest, rape, and mixed assault) in the 1984 study by Becker et al. Similarly, 56.6% (Becker et al., 1982) and 58.6% (Becker et al., 1986) of female rape and incest victims reported experiencing at least one sexual dysfunction in two other studies.

Lastly, the majority of women with sexual abuse histories in Tsai and Wagner's (1978) and Jehu et al.'s (1985) studies reported experiencing at least one sexual dysfunction. Sexual dysfunction was found in Tsai and Wagner's study to contribute to the development and perseverance of relationship difficulties. Jehu et al. reported that oftentimes sexual dysfunction was not manifested until some time after a sexual relationship was commenced.

The majority of research reviewed demonstrated that women who were molested as children often experience sexual dysfunction. The studies that reported significant findings and sexual dysfunction among adult survivors considered both clinical and non-clinical populations. These included incest and sexual abuse survivors in the community (not in treatment), seeking, entering, and in treatment; sexual assault survivors in the community (not in treatment) and in

treatment; and women presenting at emergency rooms and community mental health centers. Three studies, however, failed to report significant findings. All of these studies (Alexander & Lupfer, 1987; Fromuth, 1986; Greenwald et al., 1990) considered non-clinical populations and appear to have been biased toward higher functioning samples of sexually abused subjects, including female college students and employed women nurses. The DSM-III-R (APA, 1987) has noted that the most common onset of sexual dysfunction is early adulthood (i.e., late 20s, early 30s); thus, college students may fail to exhibit sexual dysfunction due to their young age and lack of established and on-going sexual relationships.

DSM-III-R Definitions

The essential feature of sexual dysfunction, according to DSM-III-R (APA, 1987), is "inhibition in the appetitive or psychophysiologic changes that characterize the complete sexual response cycle" (p. 290). The sexual response cycle is described as consisting of four distinct phases, including appetitive, excitement, orgasm, and resolution, and can be interrupted in any one or more of the four phases. Both the subjective experience of pleasure or desire, as well as the objective performance, is disturbed in most instances (DSM-III-R, APA, 1987).

The female sexual dysfunctions identified in the DSM-III-R (APA, 1987) include: Hyposexual Desire Disorder, Sexual Aversion Disorder, Female Sexual Arousal Disorder, Inhibited Female Orgasm, Dyspareunia, and Vaginismus. "All of the dysfunctions may be psychogenic only or psychogenic and biogenic, lifelong or acquired

(developing after a period of normal functioning), and generalized or situational (limited to certain situations or with certain partners)" (p. 291). The literature on each of these specific female sexual dysfunctions among women sexually abused as children are reviewed below.

Specific Sexual Dysfunction

Research on the long-term effects of childhood sexual abuse on adult women's functioning has increasingly focused on the existence of specific sexual problems and dysfunction as defined by DSM-III-R (APA, 1987) criteria. Abuse-related effects include multiple sexual dysfunctions, response inhibiting problems (i.e., a fear of or aversion to sex, desire dysfunction, arousal dysfunction), orgasmic problems, and intromission problems (i.e., dyspareunia and vaginismus). In addition, women who were molested as children also appear to experience other problems including flashbacks during sexual activities and increased rates of subsequent sexual assault/victimization.

Multiple Sexual Dysfunctions

Research has revealed that women survivors of sexual assault often experience multiple sexual dysfunctions. In 1982, 56.6% of rape and incest survivors in Becker et al.'s study reported experiencing at least one sexual dysfunction. In terms of multiple sexual problems, 32.4% reported experiencing two dysfunctions, 17.6% reported three dysfunctions, and 14.7% reported four dysfunctions. There were no significant differences found between dysfunctional rape and incest victims in number of sexual problems. In their 1984 study, Becker et

al. interviewed 364 sexual assault survivors. Their definition of sexual assault included rape, incest, and mixed assault (incest and rape). One sexual dysfunction was reported by 35.7% of the incest survivors in this study, while 28.6% reported two sexual dysfunctions, 25% reported three, 7.1% reported four, and 3.6% reported five.

Becker et al. (1986) interviewed 372 sexual assault survivors and 99 women with no history of assault. Sexual assault was defined as child molestation, incest, attempted rape, and rape. Among sexual assault survivors, 71% were found to experience sexual dysfunction, and their sexual problems were significantly more prevalent than those of the control group (58.6% versus 17.2%). Multiple sexual problems were reported by 66.4% of the sexual assault survivors: 30.9% reported two dysfunctions, 23% reported three dysfunctions, 9.9% reported four dysfunctions, and 2.6% reported five dysfunctions.

Multiple sexual dysfunctions are often experienced by women survivors of sexual assault. Studies of both clinical (Becker et al., 1984; Becker et al., 1986) and non-clinical (Becker et al.,1982) samples showed that approximately 66% of sexual assault survivors (including incest, child molestation, rape, attempted rape, and mixed assault) reported multiple sexual problems. Research has also demonstrated that sexual dysfunction following sexual abuse may be long-term and that "sexual sequelae differ from other assault-induced problems (e.g., depression) in that they (a) do not remit spontaneously, (b) are more enduring, and (c) need to be diagnosed and treated along with other assault-specific responses" (Mackey et al., 1991). For example, in Becker et al.'s (1984) study 60% of female

survivors were experiencing sexual problems three years or more post-assault. The discussion now turns to the specific female sexual dysfunctions adult survivors may experience.

Response Inhibiting Problems

Response inhibiting problems are those sexual problems that "would interfere with or inhibit sexual pleasure early in the sexual response cycle" and "are also likely to prevent a women from being sexual altogether, or at the very least to restrict sexual behavior significantly" (Becker et al., 1986, p. 47). These problems include fear of or aversion to sex, desire dysfunction, and arousal dysfunction. Each is considered individually and as a group below.

Research has shown that women with histories of childhood sexual abuse may experience a fear of or aversion to sex. In DSM-III-R (APA, 1987) Sexual Aversion Disorder consists of "persistent or recurrent extreme aversion to, and avoidance of, all or almost all, genital sexual contact with a sexual partner" (p. 293). Some researchers categorized subjects into the DSM-III-R category Sexual Aversion Disorder, while others asked for subjective experiences of fear of or aversion to sex. One study reviewed did not demonstrate any significant differences for the sexual aversion category between subjects who were sexually abused in childhood and those who were not (Greenwald et al., 1990).

Studies of sexual assault survivors have reported significant differences in the sexual aversion category between women who were sexually abused and women who had no history of abuse (Becker et al., 1982; Becker et al., 1984; Becker et al., 1986). In the 1982 and 1984

studies, Becker et al. found that among incest survivors 75% and 64.3%, respectively, reported experiencing fear of sex. In 1986 they found that 71% of sexual assault survivors experienced sexual dysfunction and were significantly more likely than a control group to experience fear of sex ($p < .001$).

Other studies have also reported that women molested as children often experience a fear of or aversion to sex. Gorcey et al. (1986) found that sexual relationships and functioning were significantly disrupted in 85% of women volunteers who were sexually abused during childhood, and that 43% reported experiencing fear of sex. Maltz and Holman (1987) found that 71% of incest survivors in treatment experienced fear of sex, while Jehu (1989) found that 58.8% of sexually abused women experiencing sexual dysfunction reported a phobia or aversion to sex.

Research demonstrates that women sexually abused during childhood may experience dysfunction of sexual desire in adulthood. DSM-III-R (APA, 1987) includes a category of female sexual dysfunction, Hyposexual Desire Disorder, which involves "persistently or recurrently deficient or absent sexual fantasies and desire for sexual activity" (p. 293). Two studies reviewed failed to demonstrate significant differences between women molested as children and non-molested women on measures of sexual desire. In her study of female undergraduates, Fromuth (1986) did not find significant results between a history of childhood sexual abuse and sexual desires or desire for sexual intercourse. Further, Greenwald et al. (1990), in their study of employed nurses, did not find significant sexual desire

differences between women who were sexually abused during childhood and women who were not.

The majority of the studies reviewed reported that women molested as children often experience sexual desire dysfunction. In their study of women who were sexually abused in childhood, Jehu et al. (1985) reported that approximately 50% experienced impaired sexual desire or motivation. Similarly, Jehu (1989) found that 56.9% of women entering treatment who were sexually abused as children indicated impaired sexual desire or motivation. Jackson et al. (1990) interviewed and tested 22 women who reported childhood incest and 18 women who reported no history of incest. While 65% of the women who were survivors of incest were found to meet the DSM-III (APA, 1980) criteria for at least one sexual dysfunction, 50% experienced inhibited sexual desire.

Studies of sexual assault survivors have also revealed desire dysfunction. In their study of rape and incest survivors, Becker et al. (1982) found that among incest survivors alone, 33.3% experienced desire dysfunction. Becker et al. reported similar findings in 1984; among incest survivors in that study, 35.7% reported experiencing a desire dysfunction. In another study of sexual assault survivors (including incest, child molestation, rape, and attempted rape), Becker et al. (1986) found that 55.9% experienced desire dysfunction. The investigators did not provide separate statistical findings for survivors of rape and childhood sexual abuse on specific sexual dysfunctions.

Women molested as children have also been shown through research to experience arousal dysfunction. DSM-III-R (APA, 1987) has as one of its female sexual dysfunctions, Female Sexual Arousal Disorder. This disorder involves "either persistent or lubrication-swelling response of sexual excitement until completion of the sexual activity; or persistent or recurrent lack of subjective sense of sexual excitement and pleasure in a female during sexual activity" (p. 294). While the majority of studies reviewed found women sexually abused during childhood to experience arousal dysfunction, one study (Greenwald et al., 1990) failed to show significant arousal differences between women molested as children and women who were not.

Becker et al. (1986) reported that survivors of sexual assault (including incest, child molestation, rape, and attempted rape) were more likely to experience an arousal dysfunction than was a control group ($p < .05$). Other studies have also supported the finding that women molested as children often experience dysfunction of sexual arousal. In their studies of incest survivors, Becker et al. (1982) and Maltz and Holman (1987) reported that 41.7% and 80%, respectively, experienced an arousal dysfunction. Similarly, Jackson et al. (1990) found that 35% of women who were victims of incest met the DSM-III (APA, 1980) criteria for inhibited sexual excitement. Three other studies (Becker et al., 1984; Jehu, 1989; Jehu et al., 1985) showed that approximately 50% of women who were sexually abused during childhood experienced arousal dysfunction.

Lastly, Tsai and Wagner (1987) studied 50 adult women molested as children and found that the majority of women in their

study experienced sexual dysfunction. They were able to identify three maladaptive patterns of sexual response among their subjects, including non-response and arousal contingent on control. Women in the non-response category were unable to achieve arousal with their sexual partner, while the women in the arousal contingent on control category were those who were only able to become aroused if they were in control (e.g., initiated sex, active, on top) (Tsai & Wagner, 1978).

Response inhibiting problems include fear of or aversion to sex, desire dysfunction, and arousal dysfunction. The vast majority of research, including both clinical and non-clinical samples, has revealed that women survivors of sexual abuse often experience these types of problems. In addition, they appear significantly more likely to experience them than women in control groups. Becker et al. (1984) found that response inhibiting problems were the most prevalent sexual problems reported by sexually assaulted subjects, with 88.2% experiencing at least one such problem. They also found that response inhibiting problems were experienced over three times more frequently than orgasmic problems and seven times more often than intromission problems.

Orgasmic Problems

Women with histories of childhood sexual abuse have been found to experience orgasmic difficulties. DSM-III-R (APA, 1987) describes the female sexual dysfunction, Inhibited Female Orgasm, as "persistent or recurrent delay in, or absence of, orgasm in a female following a normal sexual excitement phase during sexual activity" (p.

294). Among the studies reviewed, three failed to find a significant relationship between women molested as children and orgasmic difficulties. The first was the study by Fromuth (1986). She found no relationship between a history of sexual abuse and orgasmic capacity in female undergraduate students. The other two studies (Becker et al., 1986; Greenwald et al., 1990) failed to show significant differences between sexually assaulted/abused women and women who were not abused in terms of orgasmic difficulties.

The majority of studies reviewed showed evidence that women who were sexually abused as children experience orgasmic difficulties. Tsai et al.'s (1979) study reported that the clinical group of sexually abused subjects differed significantly from the non-clinical group in terms of frequency of orgasms; the clinical group reported experiencing orgasm less frequently than the non-clinical group. This finding appears to support Tsai et al.'s hypothesis that women molested as children who present for treatment are less well adjusted in terms of psychosexual functioning than those who do not. Feinauer (1989) found a significant interaction between the ability to have an orgasm, sexual self-esteem, and adjustment to abuse ($p < .05$) in women who were sexually abused as children. He believed this finding indicated that adjustment to abuse and sexual self-esteem contribute to a woman's ability to experience orgasm.

Studies of sexual assault survivors have also reported significant findings. Becker et al. (1982) found that while rape and incest victims did not differ in the number of sexual problems reported, they did differ significantly in the incidence of secondary non-orgasmia ($p <$

.005); incest victims reported more orgasmic difficulties. Among their subjects who were incest survivors, 33.3% reported experiencing secondary non-orgasmia (i.e., history of experiencing orgasm, but currently non-orgasmic), while 8.3% reported primary non-orgasmia (i.e., no history of experiencing orgasm). Similarly, Becker et al. (1984) found that 35.7% of incest survivors in their study experienced orgasmic problems. A comparison of the rape, incest, and mixed assault groups differed significantly only in the evidence of primary non-orgasmia, with this type of sexual problem being more prevalent among the mixed assault (incest and rape) survivors ($p < .05$).

Other researchers have also reported finding that orgasmic difficulties were often experienced by women molested as children. Langmade (1983) found that the group of incest survivors in his study reported fewer orgasms than the control group. Jehu (1989) and Jackson et al. (1990) found that 45% of their subjects (sexually abused women and incest victims, respectively) experienced inhibited or impaired orgasm.

Tsai and Wagner (1978) identified three maladaptive patterns of sexual response among women molested as children, including the ability to be orgasmic, but not considering it to be satisfying or enjoyable. These findings suggest that while women who were sexually abused during childhood "may have learned to be sexually responsive at an early age, the unpleasant associations they experience with arousal inhibits a pleasurable response" (p. 423). Similarly, Maltz and Holman (1978) indicated that women in their study who were

orgasmic often reported that such orgasms were not enjoyable. They found that 74% of the incest survivors in their study experienced lack of orgasm with a partner and 45% reported lack of orgasm under any circumstances.

The majority of the research reviewed has shown that women who were molested as children often experience orgasmic difficulties, including primary, secondary, and situational non-orgasmia (e.g., non-orgasmic with a partner, but orgasmic during masturbation), as well as less frequent orgasm than control subjects. While orgasmic problems are often experienced by women survivors and interfere with their sexual satisfaction and functioning, response inhibiting problems of fear of or aversion to sex, desire dysfunction, and arousal dysfunction, appear to be more prevalent (Becker et al., 1982; Becker et al., 1984; Jehu, 1989; Maltz & Holman, 1987).

Intromission Problems

Research has shown that intromission problems may be experienced by women who were molested during childhood. Intromission problems are those which interfere with actual sexual penetration and include dyspareunia and vaginismus. The DSM-III-R (APA, 1987) has defined dyspareunia as "recurrent or persistent genital pain in either a male or a female before, during, or after sexual intercourse" and is "not caused exclusively by lack of lubrication or by vaginismus" (p. 195). Vaginismus is defined as "recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with coitus" (p. 295).

In the research reviewed, two studies did not show significant evidence of dyspareunia among women who were sexually abused. While 56.6% of incest and rape subjects in Becker et al.'s (1982) study reported at least one sexual dysfunction, none of the incest survivors reported experiencing dyspareunia. Further, Greenwald et al. (1990) failed to find significant differences between groups of sexually abused and non-sexually abused women on measures of pain during sexual activities.

The majority of the studies reviewed, however, showed that some women molested as children may experience dyspareunia Among incest survivors in Becker et al.'s (1984) and Jackson et al.'s (1990) studies, 7.1% and 25%, respectively, reported experiencing dyspareunia. Similarly, in Jehu's (1989) study of women who were sexually abused as children, 27.5% were found to experience dyspareunia.

Other studies have reported higher incidences of dyspareunia. Maltz and Holman (1987) found that 60% of incest survivors in their study experienced painful intercourse. They also found that incest survivors under 35 years of age experienced significantly more painful intercourse than women over 35. Similarly, Feinauer (1989) found that over 56% of his subjects, women who were sexually abused as children, experienced pain or physical discomfort during sexual intercourse.

The literature reviewed on vaginismus reported mixed findings. Half of the studies did not report vaginismus among women who were sexually assaulted. Becker et al.'s (1982) study showed that while 71%

of incest and rape survivors experienced sexual dysfunction, none reported vaginismus. Similarly, in 1984, Becker et al. discovered that while 59% of their sexually assaulted subjects (including rape, incest, and mixed assault) reported experiencing at least one sexual dysfunction, none of the incest survivors reported experiencing vaginismus.

The other studies reviewed have shown low percentages of vaginismus among adult women molested as children. Jehu (1989) found that among 78% of sexually abused women who experienced at least one sexual dysfunction, only 7.8% reported experiencing vaginismus. Further, Jackson et al.'s (1990) study of 40 incest victims showed that while 65% experienced one or more sexual dysfunctions, only 19% met the DSM-III (APA, 1980) criteria for vaginismus.

Research on sexual functioning of adult women sexually abused in childhood suggests that some women may experience intromission problems, including dyspareunia and vaginismus. While the majority of studies reviewed has shown that anywhere from 7.1% to 60% of survivors may experience dyspareunia, or painful intercourse, the research has identified mixed findings and smaller percentages of vaginismus (7.8% - 10%). Thus, while intromission problems may be encountered by women molested as children, response inhibiting and orgasmic problems are more prevalent.

Other Problems

Women who were molested as children often experience flashbacks during sexual activities and appear to experience increased rates of subsequent sexual assault and victimization. While not

considered a DSM-III-R (APA, 1987) female sexual dysfunction, flashbacks have been found to interfere with women's sexual response cycle. They can "like an uncontrollable nightmare . . . instantly transport the survivor back in time, so that she mentally reexperiences the abuse" (Maltz & Holman, 1987, p. 77).

A flashback to sexual abuse may be triggered by naturally occurring thoughts and sensations during sex, such as heavy breathing or sensual touch (Maltz & Holman, 1987). Flashbacks can be accompanied by nausea and pain and result in loss of sexual desire and/or arousal. For example, Tsai and Wagner's (1978) study of women who were molested as children showed that during sexual play and intercourse flashbacks to molestations were often experienced, resulting in some women being unable to continue sexually.

Several other studies also reported the occurrence of flashbacks to victimization experiences. Gorcey et al. (1986) found that 85% of women who were sexually abused as children reported problems in sexual functioning and intimacy in sexual relationships; 11% of these women reported experiencing flashbacks to their original molestation while engaging in sexual activities. Maltz and Holman (1987) reported a much higher incidence of flashbacks among incest survivors. They found that 62% suffered from flashbacks to incest experiences during sexual activities.

Becker et al. (1986) evaluated women who were sexual assault survivors (including incest, child molestation, rape, and attempted rape) and compared them to women who were not assaulted. The investigators broke down sexual problems into categories including

early response cycle inhibiting problems, orgasmic problems, intromission problems, and other sexual problems. The two groups were found to differ in the types of other sexual problems they experienced. The other main sexual problem in the sexually assaulted group was flashbacks to assault experiences while being sexual, while for the women in the non-assaulted group the predominant problems included less intense orgasms and boredom with sex/and or sexual partners.

Research has also revealed that adult women molested as children experience increased rates of subsequent sexual assault and battery. Several studies have demonstrated significant differences in this regard between women who were sexually abused as children and women who were not abused. Fromuth (1986) found a significant relationship among female undergraduate students between a history of sexual abuse and later being raped ($p < .01$). She also reported "further analysis of this relationship revealed that, even after the Parental Support Scale was considered, a history of sexual abuse still made a unique contribution in predicting rape ($p < .05$)" (p. 12).

In their study of women with a history of childhood sexual abuse, Briere and Runtz (1987) found that there was a significant difference between women sexually abused as children and women not abused in terms of revictimization in adulthood ($p. < .01$). Of the abused women, 48.9% reported revictimization in adult relationships. Alexander and Lupfer (1987) also identified significantly higher rates of subsequent sexual assault among women sexually abused as children than among non-abused women ($p. < .01$).

Other studies also provide supportive findings. Becker et al. (1984) found that among sexual assault survivors, 60.4% had been assaulted more than once. They found significant differences between groups (incest, rape, and mixed assault), however, in number of assaults. The incest survivors incurred significantly fewer assaults (M = 1.23) than the rape (M = 3.34) or mixed assault (M = 3.5) groups ($p < .001$). McCord (1985) compared women who were victims of incest with women who were not and found that incest survivors were sexually and physically victimized as adults more often. Further, Gorcey et al. (1986) found that among women who were sexually abused in childhood, 37% were victims of later rape.

Flashbacks during sexual activities may occur and interrupt the sexual response cycle. The studies reviewed revealed that flashbacks can be triggered by a wide variety of stimuli (e.g., smells, sounds, times, places, events, sensations, sights, interpersonal dynamics) and may result in lack of desire and/or arousal and decreased sexual satisfaction (Maltz & Holman, 1987). Reported also in the literature reviewed were increased rates of subsequent sexual assault among women who were molested as children. Such women appear to experience significantly more victimization in adulthood than women with no history of childhood sexual abuse. Studies gave evidence of adult sexual assault among 37% to 60.4% of childhood sexual abuse survivors.

Conclusion

The present paper has reviewed existing empirical studies over the past 15 years which have investigated the long-term effects of childhood sexual abuse on sexual functioning. Most of these studies suggest that childhood sexual abuse does, in fact, affect adult women's sexual satisfaction and functioning. Despite methodological weaknesses among studies, predominant findings emerged. The majority of studies reviewed has shown that women molested as children expressed less satisfaction with their sexual functioning and exhibited increased rates of sexual dysfunction compared to women who were not molested.

The DSM-III-R (APA, 1987) has included six specific female sexual dysfunctions: (a) Hyposexual Desire Disorder, (b) Sexual Aversion Disorder, (c) Female Sexual Arousal Disorder, (d) Inhibited Female Orgasm, (e) Dyspareunia and (f) Vaginismus. In terms of specific sexual disorders, the research has demonstrated that women with histories of childhood sexual abuse experience all six disorders more than women with no abuse histories and often experience multiple sexual dysfunctions. However, "response inhibiting problems of fear of sex, arousal dysfunction, and desire dysfunction were the most prevalent sexual problems" found among survivors of sexual abuse (Becker et al., 1984, p. 11). Orgasmic problems were found among adult women molested as children, including impaired orgasm and decreased rates of orgasm. Intromission problems, including dyspareunia and vaginismus, were also found but in smaller percentages.

Flashbacks to molestation experiences were considered in this review of the literature. Although they are not among DSM-III-R (APA, 1987) female sexual dysfunction diagnoses, their occurrence was found in enough of the studies to warrant consideration and inclusion. Lastly, the research has indicated that women who were sexually abused during childhood experienced significantly higher rates of subsequent assault compared to women who were not sexually abused as children.

After reviewing the existing research on long-term effects of childhood sexual abuse on adult women's sexual functioning, it is apparent that there is a great need for more empirical research which utilizes large, non-clinical or combined samples, control or comparison groups, standardized measures, and statistical analysis of the data. Operational definitions of sexual abuse, including acts which constitute sexual abuse, and standard ages describing children and perpetrators, are needed to ease comparison across studies. In addition, the writer agrees with Browne and Finkelhor (1986) that the development and utilization of special outcome measures of child sexual abuse would benefit this area of research.

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